XI. OBRA '89 OB/PEDS COMPLIANCE REPORTS NEW MEXICO MEDICAID PROGRAM

CODE	DESCRIPTION	1997 PRICE
Antepartum Services		
59000	Amniocentesis, any method	81.91
59012	Cordocentesis (intrauterine), any method	214.91
59015	Chorionic villus sampling, any method	118.62
59020	Fetal contraction stress test	75.81
59025	Fetal non-stress test	49.54
59030	Fetal scalp blood sampling	127.02
59050	Fetal monitoring during labor by consulting physician with written report (separate procedure); supervision and interpretation	84.52
59051	interpretation only	35.38
Excision		
59100	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)	370.40
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	747.65
59121	tubal or ovarian, without salpingectomy an/or oophorectomy	449.88
59130	abdominal pregnancy	490.13
59135	interstitial, uterine pregnancy requiring total hysterectomy	808.39
59136	interstitial, uterine pregnancy with partial resection of uterus	547.10
59140	cervical, with evacuation	338.62
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	398.61
59151	with salpingectomy and/or oophorectomy	553.31
59160	Curettage, postpartum (separate procedure)	203.33
Introduction		
59200	Insertion of cervical dilator	48.44
Repair		
59300	Episiotomy or vaginal repair, by other than attending physician	119.37
59320	Cerclage or cervix, during pregnancy; vaginal	156.16
59325	abdominal	244.88
59350	Hysterorrhaphy of ruptured uterus	311.26

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CODE	*DESCRIPTION*	1997 *PRICE*
Vaginal Delivery, Antepartum and Postpartum Care		
*59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	1,030.85
*59409	Vaginal delivery only (with or without episiotomy and/or forceps);	605.22
*59410	including postpartum care	629.22
*59412	External cephalic version, with or without tocolysis	107.49
*59414	Delivery of placenta (separate procedure)	101.22
*59425	Antepartum care only; 4 - 6 visits	253.42
*59426	7 or more visits	434.38
*59430	Postpartum care only (separate procedure)	84.26
Cesarean Delivery		
*59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	1,478.17
*59514	Cesarean delivery only;	967.55
*59515	including postpartum care	1,040.07
*59525	Subtotal or total hysterectomy after cesarean delivery	447.20
Abortion		
59812	Treatment of incomplete abortion, any trimester, completed surgically	247.69
59820	Treatment of missed abortion, completed surgically; first trimester	274.32
59821	second trimester	255.07
59830	Treatment of septic abortion, completed surgically	371.21
59840	Induced abortion, by dilation and curettage	226.30
59841	Induced abortion, by dilation and evacuation	257.15
59850	Induced abortion, by one or more intra-amniotic injections	344.96
59851	with dilation and curettage and/or evacuation	360.72
59852	with hysterotomy (failed intra-amniotic injection)	484.34
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria);	217.62
59856	with dilation and curettage and/or evacuation	197.84
59857	with hysterotomy (failed medical evacuation)	329.73
Other Procedures		
59870	Uterine evacuation and curettage for hydatidiform mole	256.39
59899	Unlisted procedure, maternity care and delivery (% of billed after review)	

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CODE	DESCRIPTION	1997 PRICE
	Evaluation and Management	
Office Or Other Outpatient Services		
New Patient		
*99201	Physicians typically spend 10 minutes	25.14
*99202	Physicians typically spend 20 minutes	40.78
*99203	Physicians typically spend 30 minutes	54.78
*99204	Physicians typically spend 45 minutes	80.79
*99205	Physicians typically spend 60 minutes	97.09
Established Patient		
*99211	Typically 5 minutes are spent supervising or performing these services	12.07
*99212	Physicians typically spend 10 minutes	21.82
*99213	Physicians typically spend 15 minutes	31.15
*99214	Physicians typically spend 25 minutes	47.90
*99215	Physicians typically spend 40 minutes	76.43
Office Or Other Outpatient Consultations		
New or Established Patient		
*99241	Physicians typically spend 15 minutes	28.43
*99242	Physicians typically spend 30 minutes	42.03
*99243	Physicians typically spend 40 minutes	52.51
*99244	Physicians typically spend 60 minutes	64.12
*99245	Physicians typically spend 80 minutes	71.24
Confirmatory Consultations		
New or Established Patient		
99271	Usually the presenting problem(s) are self limited or minor	23.98
99272	Usually the presenting problem(s) are of low severity	32.01
99273	Usually the presenting problem(s) are of moderate severity	50.00
99274	Usually the presenting problem(s) are of moderate to high severity	48.00
99275	Usually the presenting problem(s) are of moderate to high severity	69.98

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CODE	*DESCRIPTION*	1997 *PRICE*

Home Services

New Patient

99341	Usually the presenting problem(s) are of low severity	27.43
99342	Usually the presenting problem(s) are of moderate severity	30.49
99343	Usually the presenting problem(s) are of high severity	42.84

Established Patient

99351	Usually the patient is stable, recovering or improving	22.00
99352	usually the patient is responding inadequately to therapy or has developed a minor complication	30.29
99353	Usually the patient is unstable or has developed a significant complication or a significant new problem	40.97

Prolonged Services

Prolonged Physician Service with Direct (Face-to-Face) Patient Contact

99354	Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	54.34
99355	each additional 30 minutes	26.41

Prolonged Physician Service without Direct (Face-to-Face) Patient Contact

99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	Not covered by NM Medicaid
99359	each additional 30 minutes	Not covered by NM Medicaid

Preventive Medicine Services

Codes 99381 - 99384 and 99391 - 99394 carry pricing on file, but are not billed to the Medicaid Program. All well child care is billed under the State assigned EPSDT codes.

0037W - EPSDT Screen IHS, with referral (encounter rate)	147.00
0039W - EPSDT Screen IHS, without referral (encounter rate)	147.00

EPSDT Screens for non-IHS providers are reimbursed under the following codes at $45.00.

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NEW MEXICO MEDICAID PROGRAM

CODE	*DESCRIPTION*	1997 *PRICE*

0040W - EPSDT Screen
0017W - EPSDT Screen, Outpatient Hospital, with referral
0018W - EPSDT Screen, Outpatient Hospital, without referral
0019W - EPSDT Screen, Physician, with referral
0020W - EPSDT Screen, Physician, without referral

Counseling and/or Risk Factor Reduction Intervention

Codes 99401 - 99404, 99411, 99412, 99420 and 99429 represent services which are not covered by the New Mexico Medicaid program.

Newborn Care

99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)	61.56

Medicine

Immunization Injections

Vaccines represented by codes 90700, 90702, 90703, 90707, 90712, 90713, 90716, 90720, 90730, 90737, 90744 and 90745 are provided free of charge to practitioners by the Vaccines for Children Program. New Mexico Medicaid reimburses providers $10.00 per administration.

*90701	diphtheria and tetanus toxoid and pertussis vaccine (DTP)	22.26
90704	mumps virus vaccine, live	21.00
90705	measles virus vaccine, live	19.00
90706	rubella virus vaccine, live	20.00
90708	measles and rubella virus vaccine, live	27.00
90709	rubella and mumps virus vaccine, live	28.00
90711	diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine	70% of billed
90710	measles, mumps, rubella, and varicella vaccine	70% of billed
90714	typhoid vaccine	12.00
90717	yellow fever vaccine	9.00
90719	diphtheria toxoid	9.00

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CODE	*DESCRIPTION*	*1997 PRICE*
90721	diphtheria, tetanus toxoid, and acellular pertussis vaccine (DTaP) and Hemophilus influenza B (HIB) vaccine	Not covered
90724	influenza virus vaccine	7.00
90725	cholera vaccine	11.03
90726	rabies vaccine	4.00
90727	plague vaccine	4.00
90728	BCG vaccine	4.00
90732	pneumococcal vaccine, polyvalent	14.00
90733	meningococcal polysaccharide vaccine (any group[s])	14.00
90741	Immunization, passive; immune serum globulin, human (ISG)	4.00
90742	specific hyper immune serum globulin (e.g., hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster)	6.60
90749	unlisted immunization procedure	Not covered

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Item XII. Transportation

Transportation providers are reimbursed at the lesser of the following:

a. their usual and customary charge, not to exceed their tariff rates as approved by the state corporation commission; or

b. the Department fee schedule.

The fee schedule base rate for ground ambulance includes reimbursement for the initial fifteen (15) miles of transport, non-reusable supplies, IV solution, emergency drugs and oxygen.

Item XIII. Services for EPSDT Participants

a. Services Included in the State Plan.

Services included in the state plan are described in Attachment 3.1-A. Payment for these services for treating a condition identified during a screen or partial screen is made using the same methodology described in the corresponding section of the state plan.

b. Services Not Otherwise Included in the State Plan

Payment for services described in Attachment 3.1-A, Item 4.b. (EPSDT) and not otherwise covered under the state plan but reimbursed pursuant to OBRA 1989 provisions which require the state to treat a condition identified using a screen or partial screen, whether or not the service is included in the state plan, is made as follows:

1. The following services are considered to be professional services and a reimbursed on a fee for service basis according to the fee schedule in attachment 4.19-B, I.

   (a) Therapy by a speech-language therapist, physical therapist, or occupational therapist, not covered under the state plan.

   (b) Other rehabilitative services and therapy services not covered under the state plan because they are considered maintenance rather than restorative.

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(c) Private duty nursing services, Christian science nurse services, and personal care services.

(d) Services by licensed master's level practitioners including psychologists, counselors, and social workers, and other individually licensed practitioners.

(e) Chiropractic services.

(f) Orthodontic services and other dental services not otherwise covered in the state plan.

(g) Services provided by school districts and local education agencies. Reimbursement will be at the same rate as other providers of the specific service rendered.

(h) Services provided by Licensed Alcohol and Drug Abuse Counselors (LADACs).

2. **Inpatient Institutional Services**

Inpatient services provided by JCAHO accredited institutions are reimbursed using the methodology for specialty hospitals according to the reimbursement principles of 4.19-A.

3. **Outpatient Institutional Services**

Outpatient services provided by JCAHO accredited institutions are reimbursed using the methodology for outpatient hospital according to the reimbursement principles of 4.19-B, III.

4. **Rural Health Clinic and Federally Qualified Health Center Services**

Services by these providers are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item VIII.

5. **Durable Medical Equipment, Supplies, Prosthetics, and Orthotics**

These items are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item VII.

6. **Case Management**

Case management services are reimbursed in accordance with the reimbursement methodology described in 4.19-B, Item X.

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7. Psychosocial Rehabilitation

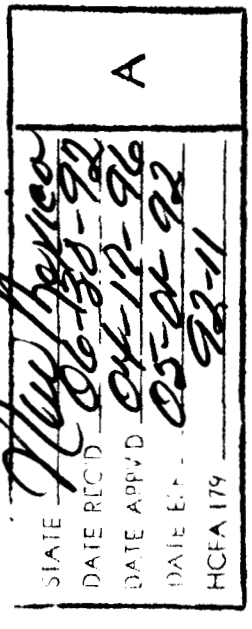
Reimbursement methodology for Psychosocial Rehabilitation services is determined by the setting/service. A multidisciplinary team establishes the level of need for each individual based upon acuity. Services provided are dependent upon the acuity level established. In residential settings, reimbursement is a daily rate based upon the acuity level. For non-residential services, the rate may be either hourly or daily, depending upon the service but does not differentiate by acuity level.

For all psychosocial rehabilitation services, provider cost information was analyzed in detail and total cost of service separated into categories associated with that service. To determine the percentage of total cost of service for each category, a range of percentages was derived from costs obtained from each provider and finally a weighted average applied.

Payment for **Residential Treatment Centers and Group Homes** is based on a resource model that defines the treatment and supervisory needs of the individuals served. This resource model was developed by the state in conjunction with a national consulting firm under contract to the Department. Rate setting decisions were made based upon the results of the consulting firm's reimbursement methodology study presented to the Department in February of 1994. Cost reports will be required from each provider in federal fiscal year 1996 and annually thereafter in order to determine appropriateness of reimbursement rates. The cost reports will be used to adjust provider rates as found necessary beginning in federal fiscal year 1997.

Provider cost information was analyzed in detail and total cost of service was separated into the following ten categories.

(1) Direct Service. These costs include all salaries, wages and benefits associated with personnel who provide daily face-to-face service to residents. Direct service staffing ratios were determined for each level of recipient for various times of day in each setting. The wage rate was based upon a Psychological Technician II classification in the New Mexico State Personnel System.



(2) Direct Supervision. Costs include all salaries, wages and benefits associated with personnel whose primary responsibilities are to oversee and coordinate the activities of the direct service staff and residents. A direct supervision wage rate and span of control was determined using a Psychological Counselor III in the State system.

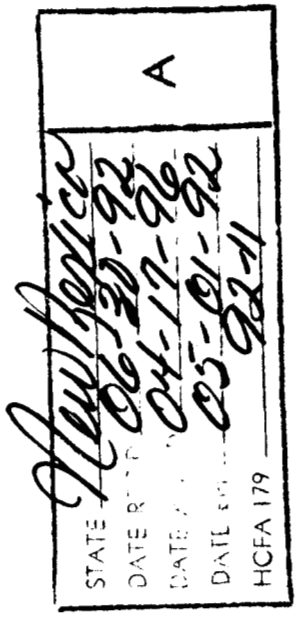
(3) Therapy costs include all salaries, wages and benefits associated with personnel whose primary activities include providing face-to-face therapy services. This category only includes costs for therapy provided by personnel on the provider agency payroll. An average caseload for therapists was derived and the wage based upon that of a Clinical Social Worker.

(4) Admission/Discharge Planning. These costs include salaries, wages and benefits associated with personnel whose sole function is to serve as a liaison between the residential program and social workers, State agencies and other residential/foster care programs. Personnel performing these activities are paid at the Social Worker Range 21 level.

(5) Clinical support costs include all salaries, wages and benefits associated with personnel whose primary activities serve to support the residential program from a clinical/programmatic perspective as opposed to an administrative perspective. Included are clinical directors, assistant clinical directors, training directors, nurses and persons who perform other types of clinical program support and coordination activities. The wage level used was that of a Psychologist III with varying caseload factors for each level of client.

(6) Education related costs include salaries, wages and benefits for personnel who serve as teachers or teacher's aides in classroom setting for the residents. These costs were then excluded from consideration in the reimbursement rate for non-accredited Residential Treatment Centers and Group Homes.

(7) Non-personnel operating costs include expenses incurred for program related supplies, transportation, and training. These were derived using 8% of total cost for all service types and levels.



SUPERSEDES: NONE - NEW PAGE